

Public Employees Benefits Board (PEBB)

Certification of Dependents With Disabilities

■ Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.

To be eligible for PEBB coverage, a dependent age 20 or older with a disability must meet the following qualifications:

1. The disability must have occurred prior to age 20 or during the time the dependent was eligible as a student (through age 23); and
2. The dependent must be incapable of self-support due to his/her disability. (See WAC 182-12-260, which defines eligible dependents.)

Subscriber: Complete Subscriber and Dependent sections; you must have your doctor complete the Physician section on the back of this form.

Subscriber Information

Last name	First name	Middle initial	Social security number		
Address			City	State	ZIP Code
Work phone number			Home phone number		

Dependent Information

Last name	First name	Middle initial	Social security number		
Date of birth (mm/dd/yyyy)	Age when disability occurred	Relationship to subscriber <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other:		Was this dependent a registered student at the time of disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	

☐ Yes ☐ No Has this dependent ever been employed?

☐ Yes ☐ No Is this dependent currently employed?

List the employer names and addresses and dates of employment (use back of form if necessary):

Insurance coverage is determined through verification of eligibility by the Washington State Health Care Authority and the health plan. I declare that to the best of my knowledge and belief that the information provided by me on this form is true and correct and that all eligibility requirements have been met. I understand that I may be subject to repayment of any claims paid by my health plan or premiums paid on my behalf if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility guidelines. I understand that failure to provide accurate information or to update information in accordance with PEBB rules may result in loss of coverage as of the last day of the month eligibility was met. A deposit of premium does not guarantee coverage and will be refunded if the dependent is determined to be ineligible for coverage.

This form supersedes all forms and submissions I have previously made for PEBB coverage.

Subscriber's signature _____ Date _____

Washington State law may require disclosure of any information I submit as public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

Agency/Sub Agency	<input type="checkbox"/> New <input type="checkbox"/> Recertification
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Physician: Complete this section *(any fee for completion of this form is the responsibility of the subscriber)*

Physician's last name

First name

Middle initial

Mailing address

City

State

ZIP Code

Is this dependent capable of employment to independently support himself/herself? ☐ Yes ☐ No

If yes, please indicate: ☐ Full-time ☐ Part-time If no, please explain why under "Nature of disability" below.

Has disability existed continuously since before age 20? ☐ Yes ☐ No If no, when did disability first exist?

Nature of disability, including diagnosis (please give as much detail as possible)

Prognosis (please estimate duration of disability)

I certify that, to the best of my knowledge and belief, the information I have provided is true and accurate.

Physician's signature Date

Mail completed form to:
Washington State Health Care Authority
P.O. Box 42684
Olympia, WA 98504-2684



Washington State
Health Care Authority
Public Employees Benefits Board

For Agency Use Only

☐ Approved ☐ Denied Effective date

Recertification date Initials